Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 07/19/01.
   b. The request was received on 05/16/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60
   b. HCFA-1500
   c. EOB
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC and Response to a Request for Dispute Resolution
   b. HCFA-1500
   c. EOBs
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 07/15/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 07/16/02. The response from the insurance carrier was received in the Division on 06/19/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of a copy of a Request for Medical Dispute Resolution is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Table of Disputed Services
   "Carrier has not sent copy of the appeal EOB even though we requested it, but states that PPE's may not exceed the value of an [sic] FCE. This is incorrect per page 60 of the guidelines. This was a PPE and NOT a muscle test."

2. Respondent: Letter dated 06/19/02

"…Carrier reimbursed requestor $100.00 for the services provided based on treatment guidelines and based on the reasoning that a PPE cannot exceed the value of an FCE."

IV. FINDINGS

1. Based on Commission Rule 133.307 (d) (1) (2), the only date of service eligible for review is 07/19/01.

2. Per the provider's TWCC-60, the amount billed is $172.00; the amount paid is $100.00; the amount in dispute is $72.00.

3. The carrier denied the billed services by code, "T – TREATMENT GUIDELINES-START TIME 11:30 END TIME 12:30 History of claim: - # of treating providers may exceed usual & reasonable, may warrant further evaluation."

4. The provider billed CPT code 97750 for the DOS in dispute.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the start time of 11:30 and the end time of 12:30 (one hour). Per the Medical Fee Guidelines, the services provided are to be reimbursed at $43.00 per 15 minute unit. Four units performed X $43.00 per each 15 minute unit = $172.00. The carrier's denial refers to the Treatment Guidelines, the start and end times, the history of the claim, and that a number of treating providers "may exceed usual & reasonable, may warrant further evaluation." The Medical Review Officer is unable to decipher or understand the meaning of the denial code. The Treatment Guidelines contain a vast amount of information and mention of the Treatment Guidelines in the denial without a specific reference or comment statement is an incomplete denial or exception code.

Rule § 134.304 (c) states, "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)…" The carrier failed to submit explanation of benefits which included the correct payment exception codes required by the Commission's instructions or provide the provider with sufficient explanation to allow the provider to understand the reason for the denial.

The carrier failed to meet the criteria set forth in Rule § 134.304 (c), therefore, reimbursement in the amount of $72.00 is recommended.

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $72.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 30th day of October 2002.

Donna M. Myers
Medical Dispute Officer
Medical Review Division

DMM/dmm